

## **NH MEDICAL CONTROL BOARD**

**Richard M. Flynn Fire Academy  
222 Sheep Davis Road  
Concord, NH**

**May 15, 2003**

**Members Present:** Donavon Albertson, MD; Frank Hubbell, DO; Jeff Johnson, MD; Jim Martin, MD; Rick Mason, Division Director; Joseph Mastromarino, MD; Douglas McVicar, MD; William Siegart, MD; Chris Fore, MD; Sue Prentiss, Bureau Chief; John Sutton, MD; Mary Valvano, MD; Norman Yanofsky, MD.

**Members Absent:** Joseph Cravero, MD; Patrick Lanzetta, MD; John Sabato, MD.

**Guests:** Eric Schelberg; Kathy Crawford; Fred Heinrich; Janet Houston; Doug Martin; Jeanne Erickson; Steve Erickson; Jon Bouffard; David Duquette; Rob Atwater; Randy Knight, MD; Donna Clark.

**Bureau Staff:** Wanda Botticello, Executive Secretary, Liza Burrill, Educational Coordinator; Kathy Doolan, Field Services Coordinator; Will Owen, ALS Coordinator; Fred von Recklinghausen, Research Coordinator; David Dow, Field Services Representative; Clay Odell, Trauma Coordinator.

### **I. CALL TO ORDER**

#### **Item 1.**

The meeting of the NH Medical Control Board was called to order by Dr. Doug McVicar at 9:10 AM on May 15, 2003 at the Evergreen 1 Building in Lebanon, NH.

### **II. ACCEPTANCE OF MINUTES**

#### **Item 1.**

**March 20, 2003 Minutes:** Motion was made by Dr. Jim Martin and seconded by Dr. Chris Fore. Motion passed unanimously.

### **III. DISCUSSION AND ACTION PROJECTS**

#### **Item 1. - Airway Modalities**

Will Owen presented information he had obtained with regards to the use of alternative advanced airways in the prehospital setting. Included in the report were:

1. Results of a literature review of alternative advanced airways in the prehospital setting,
2. Results of the alternative airway survey done by members of the MCB,
3. Results of a list serve question about the use of alternative advanced airways that was posed to all of the state Training Coordinators nationwide.

The Board reviewed and discussed each of the following alternative airways and voted on what level of provider each should be approved for:

- Esophageal Obturator Airway (EOA) and Esophageal Gastric Tube Airway (EGTA) – voted unanimous to remove from all levels of provider.
- Pharyngeal –Tracheal Lumen Airway (PtL) – voted unanimous to remove from all levels of provider.
- Esophageal Tracheal Combitube Airway – voted unanimous to approve for Basic, Intermediates and Paramedics.
- Laryngeal Mask Airway – voted unanimous to approve for Intermediates and Paramedics for use with patients over 50 kilograms. This would include all variations of the LMA including the Fasttrack, etc.
- Endotracheal Tube – voted unanimous to approve for Intermediates for adult patients and for Paramedics for adult and pediatric patients.
- Surgical Airways – was tabled for a future meeting due to time.

The Board unanimously agreed that the Bureau should develop a timeline for implementation of these changes and develop recommended educational components as needed. Will Owen stated he would develop and present a time line for implementations of these changes at the July MCB meeting and work with the Bureau's Education Staff, Dr. Fore and Dr. Sabato on determining and developing the necessary educational components.

## **Item 2. - Protocols System Improvement**

Dr. McVicar reported that approximately 70 people including hospital EMS coordinators, providers and educators attended the Protocol Process Town Meeting that was held on April 30, 2003 at the Fire Academy in Concord. He stated there was good discussion about the various topics and that the Bureau and the MCB Protocol Subcommittee gained input from everyone. Following the town meeting, the Protocol Subcommittee (made up of MCB member and EMS providers) met on May 7, 2003 to further discuss the specific issues and make

recommendation to be brought to the MCB for approval. The following recommendations were presented to the Board and voted on:

1. Recommendation: The current numbering system should be retained. A section (or sections) should be added that outline specific procedures, patient care routines, and patient assessment.

Discussion followed about the intent was to make protocols more concise and whenever possible make a single protocol instead of repeating same thing in each of the specific protocols.

Recommendation was unanimously approved as written.

2. Recommendation: No specific document format recommended. But the text needs a thorough reconstruction by a document-processing professional so that it is at least cleaned of vestigial formatting codes and published with page breaks that are stable even when text is added or deleted.

No discussion.

Recommendation was unanimously approved as written.

3. Recommendation: The protocols should be available on the World Wide Web.

Discussion followed about the need or use of a password. The recommendation was amended to say that the protocols should be available on the web without a password and that there should be a disclaimer, approved by the Board, with regards to the use and intent of the posted protocols.

The amended recommendation passed unanimously.

4. Recommendation: The protocol content revision should be timed to a two-year cycle, subdivided into regular steps and deadlines so that hospitals and other agencies can follow the process, provide timely input and plan and budget appropriately. Each new protocol approved by the MCB should be approved with a plan for implementation that includes: appropriate educational materials, other forms of support, as needed, for hospitals, squads, educators and providers and a release date (i.e. either the next biennial edition or another date). There is a need for flexibility that allows protocols to be issued sooner than the end of the two-year cycle as necessary to cover emergency situations and errata, but may also be used in other appropriate instances at the discretion of the Board.

Discussion followed about whether or not the two-year time frame was too long or short.

Recommendation was unanimously approved as written.

5. Recommendation: The present book of protocols should be expanded where needed to provide a more in-depth treatment but no attempt should be made to produce a textbook of EMS. A briefer “flip note” book of protocols should also be produced which distills appropriate material from the larger in-depth book. The material in the briefer “flip note” book should be optimized for rapid review using bullets, icons, outlines, tables, diagrams and other modalities. Appropriate color-coding is recommended. Algorithms are usually not the most rapidly accessible way to present information, so it is recommended that they be used only when necessary. The briefer “flip note” book should be capable of reflecting local option (pending question #7), and it should be produced on a trial basis with continuation in the future dependent on acceptance of the first edition.

Discussion followed. Concerns were raised about the ability to produce a useful “flip book” that could reflect local option if it was adopted in question #7. It was stated that the intent of the recommendation was that there is a desire from field providers to have a “flip book” and if it is possible to make a usable one, the Bureau will look into the feasibility of producing them.

The recommendation was unanimously approved as written.

6. Recommendation: A “one-page” Scope of Practice document should be produced for each licensed level of provider. The Scope of Practice documents should carry an explanation that they circumscribe the maximum menu for a level of licensure, but that privileges of an actual provider are based on agreement of provider, service and medical director and typically encompass less than the maximum menu.

No discussion.

The recommendation was unanimously approved as written.

7. Recommendation: Statewide consistency of protocols has distinct advantages. The MCB should move in the direction of statewide consistency whenever possible within the existing protocol framework. Specifically the MCB should expand the maximum menu wherever appropriate. The MCB should move toward more standing orders and away from protocols requiring notification of medical control. The MCB should revise and update the Statewide Protocols, which are defined in rule. The MCB should draw on the extensive span of common practice from hospital to hospital to expand the set of Statewide Protocols defined in rule.

Discussion followed about the pros and cons of both statewide and local option protocols. Dr. McVicar reported that at the Protocol Town Meeting there were many people who were in favor of Statewide protocols but there were also many people who had concerns with a

statewide system. He also raised concerns about the ability to adopt a statewide protocol under the current NH RSA. Dr. Albertson stated he felt there were 4 additional 'dimensions' of Local Option that needed to be addressed: 1) Content – Is there the ability to change the content outside the “minimum” and “maximum” menus? 2) Style and Organization – Can the style and organization of the protocols be changed? 3) On-Line orders vs. Standing orders – Can things be shifted back and forth between these? 4) Credentialing - What is the specific mechanism for credentialing, including due process? How is the relationship between a Resource Hospital and Provider operationalized? Is it a squad by squad contract? Is it a provider by provider contract? The decision was made to move the question of #7 and discuss the additional dimensions raised by Dr. Albertson as a new question #8. Further discussion followed about what types of protocols (e.g. standing orders, medical control order) should be included in rules vs. left as a local option.

The recommendation was approved unanimously as written with the adding of a question #8 to address the additional “dimensions” of local option.

8. Protocol Content – Is there the ability to change the content outside the “minimum” and “maximum” menus?

There was unanimous agreement that a Medical Resource Hospital can not add or subtract protocols outside of the “minimum – maximum” guideline, as defined in rule. But, with the understanding that there maybe some variation in what specific medication is used for a given protocol as long as it is within the same class of medication and on the approved State Medication List.

Style and Organization – Can the style and organization of the protocols be changed?

There was unanimous agreement that the Board should promote a standard style and consistency but that the Board can not mandate one style.

On-Line orders vs. Standing orders – Can things be shifted back and forth between these? Should more protocols be made standing orders?

Discussion followed about why an order/protocol should be standing vs. on-line medical control and if there should be the ability of a Medical Resource Hospital to move an order from medical control to standing order. There was discussion about that if providers are trained to do certain procedures, then they should be trained and allowed to make decisions about those procedures, and why do they need to contact on-line medical control unless they asking for assistance.

There was no consensus statement agreed upon and it was decided to pass the discussion onto the Protocol Subcommittee for further discussion. The Subcommittee will then bring forward recommendations to the entire Board.

Who is the local option protocol relationship established with? Regional/catchment area? Unit? Provider?

There was no further discussion on this issue and it was passed onto the Subcommittee to discuss and formulate a recommendation.

Credentialing - Is there specific mechanism for credentialing? How is the local option relationship between a Resource Hospital and Provider operationalized? And how is the issue of Due Process addressed?

The issue of credentialing physicians, nurses, etc. who answer the radio or phone to give medical control orders to prehospital providers was raised.

There was no further discussion on this issue and it was passed onto the Subcommittee to discuss and formulate a recommendation.

#### **IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS**

##### **Item 1. - ACEP Report.**

No report.

##### **Item 2. - Bureau of EMS Report**

Chief Prentiss referred to the written report included in each member's packet. The highlights are:

- SARS – Bureau has coordinated with Office of Emergency Management, Health and Human Services and Police Standards and Training to provide providers with the most updated information. There has been a series of video-teleconferences about SARS over the last 2 weeks and 2 evening session this coming week. The Bureau also has copies of the power-point presentation on CD. For a CD you can contact Bill Wood, Preparedness Coordinator at the Bureau..
- Bureau Reorganization – Clay Odell, RN, NREMT-P has filled the Trauma Coordinator's position. In response to the recent customer service survey and needs assessment, George Patterson has been moved into the Education group to help with the overflow of educational questions, needs, etc. in the Concord office. John Clarke, BS, NREMT-P, has filled the Trauma Grant position vacated by George.

- Air Medical Notification Project – Will Owen reported that a subcommittee was formed and developed clinical and operational guidelines for early notification of Air Medical Services. These guidelines were discussed and approved by the Trauma Medical Review Committee at their last meeting. The subcommittee and Bureau are now working on setting up evaluation sites in the Monadnock area, the Berlin-Gorham area and possibly the Concord area. Evaluation tools are being developed to track these programs and there will be a formal report given a year after the programs are up and running.
- Practical Exam Process - The Education Section of the Bureau has been developing a new BLS practical exams process to make exams more accessible and consistent. The Bureau will be meeting with Instructor/ Coordinators (IC) throughout the State to discuss the current proposal and get their feedback and input.
- Rural Health and EMS – The Bureau is working closely with the Office of Rural Health and Primary Care on managing federal money available through the Medicare Rural Hospital Flexibility Program. A certain portion of this money is dedicated to rural EMS. This year they are working to create a Rural Health Technical Assistance Center that would help address 5 focus areas including EMS. They are currently developing an EMS mini-grant program that would allow Critical Access Hospitals (CAH) to apply for money in the following areas with regards to EMS: System Analysis, System Development, Local and Regional Team Building and Strategic Planning and Quality Improvement.
- Regional Councils – Region 4 will be approaching the Coordinating Board at their next meeting to be formally approved as a Council again, and if approved all 5 Regional Councils would be active again.
- Rural AED Grant – The 2002 Rural AED Grant is moving into it's final stages. The Regional Councils have made their decisions on placement for machines. The AED bid should be completed in the next few days. Machine will then start being distributed and the North Country Health Consortium (NCHC) will begin training. The Bureau has started working on the 2003 Rural AED Grant and plan again to partner with the 5 Regional Councils, NCHC and the state Office of Rural Health Policy.

### **Item 3. - Division Report**

Director Mason commented that it was great to hear the earlier discussion about recognizing the training and abilities of EMS providers and starting to give them more latitude to utilize that training and make decisions on their own. He stated that the Bureau of EMS has come along way in the last year and he is pleased with the direction things are going.

### **Item 4. - Intersection Initiative**

No report.

**Item 5. - NH E-911 Report**

No report.

**Item 5. - Trauma Medical Review Committee**

Dr. Sutton reported that they are starting to plan for the annual Trauma Conference that will be held on November 12, 2003 at the Inn at Mills Falls in Meredith, NH. The focus will be on the issues of manpower, constraints in trauma care and different paradigms in trauma care including the increase role of ED physicians and need for surgeons. The Committee is starting to utilize the Research Section of the Bureau to start an analyze data to see how well the NH Trauma System is working. They have just started a project to look at head trauma patients.

**Item 6. - Items of Interest/Public Comment**

None.

**V. ADJOURNMENT**

**Motion** was made by Dr. Fore and seconded by Dr. Mastromarino to adjourn. Unanimous agreement adjourned.

**VI. NEXT MEETING**

July 17, 2003 at SOLO in Conway, NH. Directions are posted on the State website ([www.state.nh.us/safety/ems](http://www.state.nh.us/safety/ems)) under "Who we Are" then "Medical Control Board – Meeting Schedule" or at the SOLO website ([www.soloschools.com](http://www.soloschools.com))

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Wanda Botticello, Executive Secretary and Will Owen, ALS Coordinator)

